Care Coordination Services

What is the service?

The American Academy of Pediatrics[1] defines care coordination as a collaborative process that links children and families to services and resources in a coordinated manner to maximize the potential of children and provide them optimal health care.

The role of care coordinators in Washington State public agencies is to coordinate and connect the supports, services, and resources for children and parents at home, child care, school, and other community settings such as medical providers and managed care plans. Providers include Local Health Departments, Neurodevelopmental or Developmental Disability Centers, Regional Offices in each of the six Department of Social and Health Services (DSHS) Regions, schools, Regional Support Networks for mental health services, medical providers, managed care plans, and many others. Care Coordinators may also be parents who help other parents become Care Coordinators for their child.

Ideally, a care coordinator would be the single point of entry to facilitate services across a variety of health and educational systems. But, because the number and variety of issues facing families is so unique and the service delivery system is complex with funding from multiple sources, we now have situations where there may be more than one care coordinator for a child and family. Every situation is unique and different, and each care coordinator may address one or more type of need for the child and family. See also the *Family Support* chapter for additional services offered by peer support organizations.

How/where is the service provided?

Local Health Departments

- Children with Special Health Care Needs (CSHCN) Coordinators are public health nurses located in local health departments across the state.
- CSHCN Coordinators help families access needed services for their children ages birth to 18 such as medical care and other interventions; refer families to health insurance programs, provide screening, and conduct assessment.

Local Contractors of the Infant and Toddler Early Intervention Program (ITEIP)

- Throughout the state, Family Resources Coordinators (FRC) provide service coordination activities for children birth to three. Each FRC has demonstrated knowledge and understanding about infants and toddlers eligible under Individuals with Disabilities Education Act (IDEA), Part C, the regulations in Part C 34, CFR Part 303, the nature and scope of services available under Washington State's Infant Toddler Early Intervention Program (ITEIP), the system of payment for services in Washington State programs, and other pertinent information.

[1] Pediatrics Vol.104 No. 4 October 1999, 978-981.

- The FRC is responsible for:
    1. Coordinating all services across agency lines.
    2. Serving as a single point of contact in helping parents to obtain the services and assistance they need.
    3. Assisting parents in gaining access to early intervention services and other services identified in the Individual Family Service Plan (IFSP).
    4. Coordinating the provision of early intervention services and other services that the child needs or receives.
    5. Facilitating the timely delivery of available services, and continuously seeking appropriate services and situations necessary to benefit the development of each child served for the duration of the child's eligibility.

Regional Offices in each of the six DSHS Regions and outstations in the Regions

- Division of Developmental Disabilities (DDD) Case Resource Managers determine eligibility for services, identify needs, and develop, monitor, and coordinate service plans. This person also authorizes payments for division services and other services available though the Aging and Disabilities Services Administration.

- The DDD Case Resource Manager is responsible for:
    1. Determining eligibility for DDD services.
    2. Doing needs assessments.
    3. Developing a Plan of Care for people with DDD waivers.
    4. Completing a Mini Assessment (by 2006) on people eligible for DDD but receiving no paid service.
    5. Completing a Full Assessment (by 2007) on all people receiving DDD service.
    6. Authorizing services via Social Services Payment System.
    7. Monitoring and coordinating authorized services.
    8. Providing resource information and referral services for clients birth through adulthood.
    9. Participating in County Interagency Coordinating Council efforts.

Schools

- School Nurses provide case management for students in her/his case load and interact with parents, providers, community, and school resources to provide a school environment that is safe, healthy, and conducive to learning.

- Case management of children with special health care needs involves activities designed to ensure the health and educational success of the child at school. It is the position of the National Association of School Nurses that school nurses have knowledge, experience and authority to be the case manager for children with special health care needs. This includes, but is not limited to:
    1. Having knowledge about services needed by students with special health care needs, after collaboration with student, family and health care provider.

2. Having knowledge about community services and assisting families in obtaining needed services.
3. Screening for students who would qualify and benefit from case management services for their health care needs.
4. Providing leadership in interdisciplinary team meetings to assist in planning needed services to meet the health and educational needs of the students.
5. Implementing the health team's care plan by providing direct or indirect care.
6. Coordinating continuity of care between home and school.
7. Monitoring and evaluating interventions and implementation of the health care plan.
8. Monitoring and evaluating progress toward health and educational goals.
9. Training, monitoring, and evaluating personnel delegated to perform specific nursing care.

Regional Support Networks

- Mental Health Rehabilitation services are integrated treatment services recommended by a mental health professional and provided by state licensed Community Mental Health Agencies. Services are provided to seriously mentally ill adults and seriously emotionally disturbed children for whom the services are determined to be medically necessary. These services must be provided to reach the goals of an Individualized Service Plan.

Medical Homes

- A Medical Home is an approach for providing health care and community services in a coordinated way. It is not a place. It's a relationship with a group of doctors, nurses, and other health care providers who know the children and their families. Medical Homes include pediatrician offices, family practice offices, or clinics that provide or arrange for care coordination for children with special health care needs. In a Medical Home, a child's health care provider knows and respects the child and the family, understands the child's needs, provides routine care like regular checkups and immunizations, works as an equal partner with families to make decisions about the child's health, and helps to coordinate the child's health care.
- **Tools to help organize a child's health information**
    1. Children's Hospital and Regional Medical Center's Care Notebook
    2. Mary Bridge Children's Hospital Care Notebook
    3. Los Angeles Medical Home Project Parent Notebook *(available in Spanish)*
    4. Washington State Medical Home website: http://www.medicalhome.org
- **Find community resources**
    1. Starting Point Resource Guide – Washington State
    2. Washington State County Resource Guides
- **Information about financial planning for children with special health care needs**
    1. American Academy of Pediatrics Future and Estate Planning

2. Exceptional Parent Magazine Life Planning

- **Preparing for a child's visit to the doctor**
  1. Bright Futures for Families - Materials
  2. "Building Early Intervention Partnerships With Your Child's Doctors: Tips from and for Parents (WA State Infant toddler Early Intervention Program, Department of Social and Health Services).

Who is receiving the Service?

(Note: The following programs are not mutually exclusive. Numbers should not be added together.)

CSHCN Programs in Local Health Departments
Number of Clients (0-18) in Washington State, 2004

	# clients[2]
Total Number of Children Served	10,185

Infant and Toddler Early Intervention Program (ITEIP)
Number of Children (0-3) in Washington State, October 2003- September 2004

	# clients [3]
Total Number of Children Served	6,806

Developmental Disabilities, 2004
Number of Children (0-17) in Washington State, July 2002 – June 2003

	# clients [4]
Total Number of Children Served	16,225

Regional Support Network, 2004
Number of Children (0-17) in Washington State, July 2002 – June 2003

	# clients [4]
Total Number of Children Served	37,175

[2] Child Health Intake Form (CHIF) statewide database, Washington State Department of Health, CSHCN Program, 2004.
[3] Infant and Toddler Early Intervention Program (ITEIP) data, October 2003-September 2004.
[4] DSHS Human Services in Your County, July 2002 – June 2003. Research and Data Analysis Division. Washington State Department of Social and Health Services, 2005. Available at http://www1.dshs.wa.gov/pdf/ms/rda/clientdata/03state.pdf

Schools in Class I Districts

The 66 Class I districts indicate the number of identified cases of specific health conditions. Additionally, these districts report the number of each specific health condition considered life-threatening per RCW 28A 210.320. This information is another data source pointing to the number and severity of health conditions present in school districts across the state. For the 2003-04 school year, the 66 Class I districts reported the following data:[5]

Disease/Condition	Number of Diagnosed Cases	Percent of Student Population	Number of Life-Threatening Cases	Percent of Diagnosed Cases Considered Life-Threatening
Asthma	28,836	5.2	2,314	8
Diabetes	1,394	0.2	1,204	86
Severe Allergies	7,765	1.4	4,199	54
Heart Conditions	1,866	0.3	262	14
Seizures	3,013	0.5	859	28
ADHD/ADD	17,544	3.0	105	.06
Neuropsychological Disorders	4,548	0.8	188	4
Others	2,475	0.4	297	12
Total	67,441	12.0	9,428	14

Issues/Concerns

- The system of care for children with special health care needs is complex, making it difficult for families to identify payment sources, locate family support, and access needed services. Families need and desire a primary point of contact for care coordination who helps them navigate the health, social service, and educational systems and can most adequately meet the needs of the child and family.
- Care coordination in Washington State is fragmented.
- In many cases, a child's care coordinator coordinates only portions of the scope of services that the child uses.
- In many cases, a child may have multiple care coordinators from multiple agencies who may not communicate with each other.
- The term care coordinator has different meanings among agencies.
- Many of the policy and procedure barriers can be addressed through increased communication and collaboration across local agencies.

[5] Washington State Office of Superintendent Public Instruction, 2004.